



Family Planning for Married Adolescent Girls

- *Married adolescent girls are highly vulnerable, yet health care providers and the community often ignore their needs.*
- *Avoiding early childbearing is crucial to preventing maternal and infant mortality. Addressing the high unmet need for family planning in this group is a key strategy.*
- *Programs need to lower the many hurdles these girls face in using a family planning method and to ensure good access and quality.*

Married adolescent girls are perhaps the most vulnerable of all segments of the sexually active population—exposed at a young age to the risks of infection, pregnancy, and childbirth and yet mostly without the protection afforded by education, economic security, social networks, and a mature body physiologically ready to bear children. Early marriage (defined here as before age 18) is especially common among girls in West Africa, South Asia, and in some countries in Latin America.

Family Planning Needs

Married adolescent girls have many profound needs, and yet they have little power to meet those needs and to make autonomous decisions affecting their own welfare. Avoiding early childbearing is one of the most acute needs of married adolescent girls, and strengthening family planning programs and policies to help married girls—and their spouses—postpone first births and space subsequent births should be a high priority for reproductive health programs.

Childbearing during the early adolescent years harms both mother and child. The risks of maternal morbidity (including obstetric fistulas), maternal mortality, and infant mortality are much greater than for mature women. Nevertheless, adolescent childbearing is common in large parts of the developing world. In sub-Saharan Africa the majority of women have given birth at least once by the time they reach age 20. Research shows that most young married girls in developing countries do not want to bear children at such early ages. Nor do they want to bear the burden of repeated pregnancies and large families while they are themselves still children. Yet, in many situations young married girls are under pressure to demonstrate their fertility soon after marriage, and they lack the autonomy to make decisions about contraception and other aspects of their reproductive lives.¹ The pressure to bear children soon after marriage frequently comes from the husband and/or mother-in-law and has obvious implications for both the decision to use contraception and the type of contraceptive to use.

In such an environment a young married girl faces many challenges in order to postpone her first pregnancy and space subsequent pregnancies (ideally at least three years between pregnancies). These obstacles are not unique to married adolescents, but in many ways they are accentuated in this group. These hurdles include:

- gaining the husband's support for postponing/spacing births;
- identifying an outlet (clinic, pharmacy, or community-based worker) where family planning methods can be obtained at an affordable price;
- receiving a method from a provider without discrimination on the basis of age or parity or other medical barriers;
- learning how to use a family planning method correctly;
- receiving an adequate supply of contraceptives that require resupply—especially relevant for married adolescents, given their limited mobility and social interaction; and
- tolerating any side effects of the method.

Although these obstacles are difficult to overcome, program interventions can address them by focusing on the needs of individual clients, including quality and access issues.

Contraceptive Options

A married adolescent girl has many contraceptive options to help her postpone her first birth and space subsequent births. The World Health Organization's Medical Eligibility Criteria do not rule out any method on the basis of age alone.² Nevertheless, some methods are likely to be more appropriate than others, based on the personal characteristics of the client. For example, female sterilization is rarely, if ever, appropriate for married girls (although medically eligible) because most girls want children in the future.



In developing countries overall, oral contraceptives (OCs) are the method that married girls age 15-19 most commonly use. (In contrast, condoms are more popular among unmarried girls.) As use of injectables continues to grow, this method is beginning to supplant OCs in some countries as the preferred method among this age group.

Program Implications

The most important way that a program can reduce the risks associated with early childbearing is to work with communities, policy makers, and families to change community norms, enhance education for girls, and take other steps to help delay early marriage.³ To meet the family planning needs of adolescent girls already married, programs can address needs at multiple points:

1. Provide education and services to recently married girls not yet pregnant, as well as to their husbands and extended families. Promote the delay of first births, focusing on the risks of early pregnancy and the advantages of postponing the first pregnancy for at least one year. Provide family planning education through multiple outlets (commercial, nontraditional, and facility-based).
2. Provide education and services to pregnant married girls or those who have recently given birth or had an abortion. Promote the spacing of pregnancies by at least three years, focusing on its protective effect for mother and infant. Promote family planning methods for spacing, as well as breastfeeding and the lactational amenorrhea method.
3. Improve access and quality of family planning services to married girls by removing medical and institutional access barriers (such as parity or age requirements and judgmental attitudes), undertaking community-based outreach to married girls, and taking advantage of all contacts with the health care system to promote and provide family planning (e.g., as part of HIV counseling and testing, perinatal care, and postabortion care).

Special Considerations When Counseling

When counseling young married girls about their family planning options, counselors should keep in mind the following points. These points are meant to suggest areas where additional counseling may be needed and are not meant to imply that some methods should never be used.

- For many adolescents, methods that do not require daily action are preferable.
- Adolescents, married or unmarried, are less tolerant of side effects and therefore have high discontinuation rates.
- For girls who are pregnant or have recently given birth, counseling should address the special issues of postpartum contraception (see Global Health Technical Brief #16, Family Planning for Postpartum Women).
- DMPA has effects on bone density and for girls under 18 is a category 2 method in WHO's Medical Eligibility Criteria², indicating that the advantages of using the method generally outweigh theoretical or proven risks. A further consideration is that return of fertility is delayed about 10 months from the last injection (about 4 months longer on average than after use of other methods).
- Girls under age 20 and girls who have had no children generally can use IUDs, WHO advises in its 2004 Medical Eligibility Criteria for Contraceptive Use. Although these girls are at increased risk of expulsion, the advantages of the IUD generally outweigh the risk of expulsion.
- Fertility awareness methods are more difficult to use for girls who have recently reached menarche.
- Married girls who lack social networks and transportation may find it difficult to obtain provider-dependent methods such as IUDs and implants. Injectables, although available in pharmacies and some community-based distribution programs, also may be hard to obtain.
- Girls who marry young often have much older spouses who, by virtue of their age and sexual experiences, may be particularly likely to have HIV infection. Girls and their married partners should be encouraged to get tested for HIV. For HIV-discordant couples, condoms are a must to protect the partner from infection. For most married girls who do not know their HIV status or that of their partner, and especially where HIV prevalence is high, use of condoms should be explored and destigmatized. Married girls need to know that only condoms can protect them from HIV and STIs.

¹ Mathur S, Greene M and Malhotra A. Too Young to Wed: The Lives, Rights, and Health of Young Married Girls. Washington, DC: International Center for Research on Women, 2003.

² Medical Eligibility Criteria for Contraceptive Use. Third Edition. Geneva, World Health Organization, 2004. Available at: <http://www.who.int/reproductive-health/publications/mec/index.htm>

³ Haberland N, Chong EL, and Bracken HJ. Early Marriage and Adolescent Girls. YouthLens No. 15. Arlington, VA: FHI/YouthNet, 2005

Where to get more information: <http://www.maqweb.org>

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